“What’s New” Medical Policy Updates October 2024

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of September that will become **effective November 15, 2024** (unless otherwise specified). The Plan uses medical policies as guidelines for coverage decisions made within members written benefit documents. Coverage may vary by line of business and providers and members are encouraged to verify benefit questions regarding eligibility before applying the terms of the policy.

MP021 Dorsal Column Stimulation – Revised – Clarified Indications

INDICATIONS: REQUIRES PRIOR PLAN AUTHORIZATION. The authorization must be requested and approved prior to the implantation of the electrodes for the trial period.

Relief of chronic intractable lumbar or thoracic pain under the following circumstances:

- Lumbosacral arachnoiditis that has not responded to medical management including physical therapy. (Presence of arachnoiditis is usually documented by presence of high levels of proteins in the CSF and/or by myelography or MRI.)
- Nerve root injuries, post-surgical or post traumatic including that of post laminectomy syndrome (failed back syndrome)
- Complex regional pain syndrome I & II (upper or lower extremities)
- Diabetic peripheral neuropathy (DPN)
- Phantom limb syndrome that has not responded to medical management
- End stage peripheral vascular disease, when the member cannot undergo revascularization or when revascularization has failed to relieve painful symptoms and the pain has not responded to medical management
- Post- herpetic neuralgia
- Plexopathy
- Intercostal neuralgia that did not respond to medical management and nerve blocks
- Cauda equina injury
- Incomplete spinal cord injury.

CRITERIA FOR COVERAGE: All must be met

- The implantation of the stimulator is used only as a late resort (if not a last resort) for members with chronic intractable pain and;
- Documented failure or contraindication to physical therapy or chiropractic care (if clinically applicable). There must be documentation of a minimum of 4 weeks of physical therapy or chiropractic care at least 2 times per week for the four weeks (minimum of 8 visits) within one year of the request for dorsal column stim trial/implantation. ~~injections. The therapy MUST be associated with the body area that will be treated with the requested injections.~~ A home exercise program is not an adequate substitute for formal physical therapy or chiropractic care. If the provider indicates the member cannot do physical therapy or chiropractic care due to pain, the provider must submit documentation from an evaluating physical therapist or chiropractor dated within 4 weeks of the request indicating the member cannot tolerate therapy services~~. Please note that one visit for injection to allow the member to attend therapy is not considered medically necessary~~. Please also note that completion of less than the minimum number of therapy or chiropractor visits due to non-compliance is not an acceptable alternative to this requirement in the absence of documentation the member was unable to tolerate therapy services; and

MP065 Obesity Surgery – Revised – Revise AAP guidance criteria for adolescents

ADOLESCENT CRITERIA

The surgical treatment of morbid obesity (i.e. open or laparoscopic Roux-en-Y gastric bypass, or open or laparoscopic sleeve gastrectomy) may be considered medically necessary when all of the following criteria are met:

a) Medical documentation of a diagnosis of morbid obesity defined as:
   i. Class 3 obesity (BMI of 40 kg/m^2) or greater; OR greater than 140 percent of the 95th BMI percentile for age with ANY obesity-related comorbidity;

   or

   ii. Class 2 obesity (BMI of 35 - 39 kg/m^2) OR greater than 120 percent of the 95th BMI percentile for age with at least one of the following comorbidities:
      - type 2 diabetes
      - obstructive sleep apnea diagnosed by polysomnography
      - pseudotumor cerebri
      - Poorly controlled hypertension despite pharmacotherapy (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater)
      - hyperlipidemia
      - non-alcoholic steatohepatitis

   and

b) One of the following surgical interventions is planned:
   - open or laparoscopic Roux-en-Y gastric bypass
   - open, laparoscopic, sleeve gastrectomy

   and

c) The member is ~~15~~ 12 years of age or older; and
d) Documentation of previous failure of physician-supervised weight loss attempt; and
e) Pre-Surgical Program
   - Adolescent members considering surgery must participate in a comprehensive program with documentation of the following:
      - the member has been evaluated by the multidisciplinary pediatric team and is determined to be physically and emotionally mature enough to participate in the program
      - the member demonstrates the ability to adhere to the principles of healthy dietary and activity habits
      - the member has adequate support system and resources to achieve weight loss goals
f) Surgery for morbid obesity must be performed in an institution designated by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) and accredited. Facility participation in the Geisinger Bariatrics Proven Care® program will be considered in lieu of the designation as a COE by MBSAQIP. **(Not Applicable to Medicare and Medicaid)**

LIMITATIONS:

Revision of bariatric surgery: <u>Bariatric surgery revision requires prior authorization</u>

Coverage is limited to one bariatric surgery per lifetime regardless of insurance carrier at the time of surgery with the following exceptions:

- Bariatric surgery revision will be considered for coverage **<u>only</u>** when requested as treatment for an associated medical complication such as, but not limited to obstruction, fistula or stricture for which no other treatment option is available, bowel perforation, band erosion or migration, or band failure.
- Conversion from sleeve gastrectomy to Roex-en-Y will be considered for coverage for the treatment of refractory gastroesophageal reflux when less invasive treatments and therapies have proven to be contraindicated or have resulted in therapeutic failure.

Inadequate weight loss due to individual noncompliance with postoperative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not covered by the Plan.

Laparoscopic adjustable silicone gastric banding (LASGB) requests will be reviewed on a per-case basis and considered for coverage only by exception.

Incidental cholecystectomy is considered covered in the presence of signs and/or symptoms of gallbladder disease, finding of a grossly diseased gallbladder at the time of operation or a history of metabolic derangements that will result in symptomatic gallbladder disease following bariatric procedures.

Medicare Business Segment:

See: National Coverage Determination. Bariatric Surgery for Treatment of Morbid Obesity 100.1
See: Bariatric Surgery for the Treatment of Morbid Obesity   CAG-00250R

MP274 Diapers and Incontinence Supplies – Revised – Clarify exclusion and coverage

INDICATIONS: Requires Prior Authorization by a Plan Medical Director or Designee

FOR MEDICAID BUSINESS SEGMENT:

Generic Disposable Diapers, and Disposable Under Pads are covered when the following criteria are met:

- The insured individual is three years of age or older; and there is physician documentation of one of the following types of urinary incontinence:
    - Stress – urine loss caused by increased intra-abdominal pressure;
    - Urge – urine loss caused by involuntary bladder contraction;
    - Mixed – urine loss caused by a combination of stress and urge incontinence;
    - Overflow – urine loss when urine produced exceeds the bladder's holding capacity; and
    - Total – uncontrolled or continuous leakage caused by neurological dysfunction, abdominal surgeries, or anatomical defects.

      or
    - Urinary incontinence accompanied by fecal incontinence

      or
    - Fecal incontinence

and

- Physician documentation of a history and physical exam to detect contributing factors and reversible causes such as:
    - medical conditions, such as delayed developmental skills, fecal impaction, psychosis, or other neurological diseases that affect motor skills;
    - symptomatic urinary tract infection;
    - evidence of atrophic urethritis/vaginitis;
    - medication regimens that include diuretics, drugs that stimulate or block the sympathetic nervous system, or psychoactive medications;
    - environmental conditions (for example, impaired mobility, lack of access to a toilet, restraints, restrictive clothing, or excessive beverage intake); and
    - social circumstances that prevent personal hygiene (for example, inconsistent caregiver support for toileting)

and

- Physician documentation of results of diagnostic testing as deemed appropriate by the ordering provider. (Examples include: pelvic exam in women, rectal exam, urinalysis with culture and sensitivity, urologic testing and/or consultation, developmental assessment in children);

and

- There is physician documentation of failure of a bowel/bladder training program; or documentation that the insured individual cannot participate or would not benefit from a bowel/bladder training program;

and

- Physician documentation that pharmacologic therapy and/or surgical intervention to manage symptoms of incontinence have failed or are contraindicated;

and

- the physician submits a prescription which includes the following information:
  - A diagnosis of medical condition causing the incontinence.
  - The item(s) to be dispensed, the number that will be used per day, and anticipated duration of need.
  - The quantity of item(s) requested.

Pull on briefs are covered for a six-month period if all the following criteria apply:

- Physician documentation of a medical condition causing bowel/bladder incontinence; and
- The insured individual is actively participating in a bowel/bladder training program

For continued coverage beyond initial six months, a reassessment must be completed every six months.

LIMITATIONS:
Diapers and Pull-up Briefs — for the insured individual using both diapers and pull on briefs, the total quantity of these items combined cannot exceed 300 per month. Any request for an amount beyond the 300 limit will require documentation of medical necessity and review by the GHP Family Medical Director.

Diapers of Different Sizes — for an insured individual using a combination of different sized diapers, the total quantity must not exceed 300 per month.

Under pads are limited to 180 per 90 days.

EXCLUSIONS:
For GHP Family, coverage for diapers and incontinence supplies will be considered not medically necessary when any of the following are present:

- Possible reversible conditions have been identified, but no treatment or plan has been initiated to manage the incontinence.
- Products are used solely for the management of nocturnal enuresis that has not been addressed through other treatment measures.
- Products are provided solely for the convenience of the member or service provider.
- Incontinence wipes provided solely for the convenience of the member or service provider

COMMERCIAL AND MEDICARE BUSINESS SEGMENT:

Diapers and Incontinence Supplies are disposable supplies and **NOT COVERED**

MP284 Bone Mineral Density Measurement – Revised – Add Trabecular Bone Score

Trabecular Bone Score
Trabecular bone score (TBS) to predict fracture risk is **NOT** considered to be a component of the USPSTF osteoporosis screening strategy and is therefore not covered as a screening service. TBS use will be subject to any applicable member deductable and cost sharing.

MP302 Percutaneous Tibial Nerve Stimulation – Revised – Add Exclusion

EXCLUSIONS:
If the insured individual exhibits no improvement in OAB symptoms after 12 PTNS treatments, continued treatment is considered not medically necessary, and **NOT COVERED**

PTNS for the treatment of all other indications, is considered experimental, investigational or unproven and, is **NOT COVERED.**

Subcutaneous tibial nerve stimulation (STNS) {e.g.., eCoin System, REVI System} is considered **UNPROVEN** and therefore **NOT COVERED** for any indication. There is insufficient evidence in the published peer-reviewed medical literature to show this technology imparts improved outcomes compared to current standard technologies.

MP363 Urinary Tumor Markers for Bladder Cancer – Revised – Add Medicare Language

DESCRIPTION: The purpose of using urinary tumor markers in the evaluation of members who exhibit signs or
symptoms of bladder cancer is to serve as an adjunct to cytology and biopsy. The current standard for a confirmatory diagnosis of bladder cancer is cystoscopic examination with biopsy.

~~CRITERIA FOR~~ **General Coverage:**
Urinary biomarkers (bladder tumor antigen (BTA) test, nuclear matrix protein (NMP22) test, or fluorescence
in situ hybridization (FISH) {*UroVysion Bladder Cancer* test} may be covered when used as:
a. An adjunct in the diagnosis of bladder cancer for members who have an atypical or equivocal cytology
b. An adjunct in the monitoring of high-risk, non-muscle invasive bladder cancer

The use of fluorescence immunocytology {*ImmunoCyt/uCyt*} may be covered as an adjunct to cystoscopy or cytology in the monitoring of members with bladder cancer.

See Also: AHS G2125 Urinary Tumor Markers For Bladder Cancer

Medicare Business Segment:

In compliance with ~~Novitas LCD A52986 A58529~~ Response to Comments: Bladder/Urothelial Tumor Markers A55457 ~~Biomarkers for Oncology, **Cxbladder™ Detect, Cxbladder™ Monitor** will be covered when meeting the reasonable and necessary guidelines as outlined in Title XVIII of the Social Security Act, Section 1862(a)(1)(A~~). As a laboratory-developed test (LDT), the analytical validation, clinical validation and the clinical utility for Cxbladder™ has not been assessed by MolDX. Cxbladder™ is considered investigational and not covered by Medicare.
Response to Comments: Genetic Testing for Oncology A59417 Regarding CxBladder testing: “In summary, these tests do not have sufficient evidence to warrant coverage in Medicare patients.”

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EXCLUSIONS:
There is insufficient evidence in the peer-reviewed, published medical literature to support the use of urinary biomarkers (bladder tumor antigen (BTA) test, nuclear matrix protein (NMP22) test, fluorescence in situ hybridization (FISH) UroVysion Bladder Cancer test) or fluorescence immunocytology (ImmunoCyt/uCyt) as mechanisms for bladder cancer screening, evaluation of hematuria, or diagnosing bladder cancer in symptomatic members. These tests are considered to be ~~**Experimental, Investigational or**~~ **Unproven** for those indications and are therefore **NOT COVERED**.

There is insufficient evidence in the peer-reviewed, published medical literature to support the use of gene expression profiling by real-time quantitative PCR {Cxbladder Detect, Cxbladder Monitor}. ~~Unless otherwise mandated (eg, Medicare),~~ , The Plan does **NOT** provide coverage for Proteomic Serum analysis to bladder cancer. These tests are considered to be **~~Experimental, Investigational or~~ Unproven** for those indications and are therefore **NOT COVERED.**

The following policies have been reviewed with no change to the policy section. Additional references or background information was added to support the current policy.

MP024 External Counterpulsation
MP053 Cochlear Implant
MP059 Fetal Surgery
MP069 Ultrafiltration
MP116 Hippotherapy
MP117 Dry Hydrotherapy
MP120 Intracavitary Balloon Brachytherapy for Breast Cancer
MP181 Suit Therapy
MP228 HPV DNA Testing
MP306 Tumor Treatment Fields
MP330 Responsive Neurostimulation
MP371 Intraosseous Basivertebral Nerve Ablation
MP373 Medication Assisted Treatment
MP118 Quantitative Sensory Testing
MP161 Thermal Capsulorraphy
MP218 Serum Antibodies for the Diagnosis of Inflammatory Bowel Disease
MP329 Genicular Nerve Ablation
MP347 Central Auditory Processing Disorder
MP364 Fecal Analysis for Diagnosis of Intestinal Dysbiosis